STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX **File No. 86690-001-SF**
Petitioner
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 14th day of January 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 11, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006, MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on December 18, 2007. As required by section 2(2) of Act 495, the Commissioner conducts this external review as though it were an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on January 2, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Professional Services Group Benefit Certificate* (the certificate). The

Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner had back surgery on August 14, XXXX, provided by XXXXX, a nonparticipating provider (i.e., he has not signed an agreement with BCBSM to accept its approved amount as payment in full for his services). XXXXX charged $5,762.50 for the surgery and BCBSM paid $1,765.15 as its approved amount. This left the Petitioner to pay the balance of $3,997.35.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on October 4, 2007, and issued a final adverse determination dated October 17, 2007.

III
ISSUE

Is BCBSM required to pay any additional amount for the surgery provided to the Petitioner on August 14, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says it was determined in August 2007 that she required back surgery. Her primary care physician indicated it was dangerous to wait and the surgery needed to be done as soon as possible. The Petitioner was unable to find a participating surgeon close to her home that could treat her timely and so she arranged to have the surgery done by XXXXX. The Petitioner says she asked BCBSM to find a participating surgeon who could provide the surgery quickly, but they were unable to do so.

Consequently, BCBSM only paid 31% of the amount charged for the Petitioner's back surgery. The Petitioner believes that BCBSM should be required to pay at least 50% of the charges because of the circumstances. The Petitioner feels that it is totally unfair for BCBSM to put its

subscribers in a position where they need to choose between receiving treatment and putting their health in jeopardy.

BCBSM's Argument

BCBSM says that Section 2 of the certificate, *Coverage for Physician and Other Professional Services,* explains that it pays its "approved amount" for physician and other professional services -- the certificate does not guarantee that provider charges will be paid in full. Since the Petitioner's surgeon did not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full.

The amounts charged by the surgeon and the amounts paid by BCBSM for the August 14, XXXX surgery are set forth in this table:

Procedure Code	Amount Charged	BCBSM's Maximum Payment Amount	BCBSM's Approved Amount	Amount Paid by BCBSM	Petitioner's Balance
63030	$ 4,936.00	$ 1,417.43	$ 1,417.43	$ 1,417.43	$ 3,518.57
69990	$ 826.50	$ 347.72	$ 347.72	$ 347.72	$ 478.78
Totals	$ 5,762.50.	$1,765.15	$1,765.15	$ 1,765.15	$ 3,997.35

In determining the maximum payment level for each service, BCBSM says it applies a resource based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice. There is nothing in the certificate that requires BCBSM to pay more than its approved amount even if the care was provided for a life-threatening condition or even if there were no participating providers available.

BCBSM believes that it has paid the proper amount for the Petitioner's care by a nonparticipating provider and is not required to pay any additional amount.

Commissioner's Review

The certificate describes how benefits are paid. It explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or our [BCBSM's] maximum payment level for the covered service." According to the certificate, participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges. The certificate contains this warning (on page 2.25):

> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment may be less than the amount charged by the provider.

BCBSM paid for the Petitioner's surgery of August 14, XXXX, based on its full approved amount for both procedures.

It is unfortunate that the Petitioner was in a situation where she was not able to use a participating surgeon. Nevertheless, BCBSM is correct: there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount to nonparticipating providers, regardless of the circumstance.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of October 17, 2007, is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham

County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.